Understanding RVUs

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TMA Uniform Business Office
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Scarce Resources

- 1,000 of your beneficiaries need vaccine X
- 1,000 units of vaccine available
- 3 MTFs
  - MTF A has 333 patients
  - MTF B has 333 patients
  - MTF C has 334 patients

Scarce Resources

MTFs asked to identify number of units needed

- MTF A says 500
  - (MTF has bad data, mostly patients with multiple registrations)
- MTF B says 500
  - (MTF has bad data, mostly bad coding where numbers were juxtaposed so instead of ear infections the patients all have some unusual disease, and the MTF did not get enough for all their patients last time and they plan to have enough this time)
- MTF C says 334

Scarce Resources

How supplies are split

- 1,000 available with demand of 1,334
- Each MTF gets 1,000/1,334 x request
- MTF A gets .75 x 500 = 375
- MTF B gets .75 x 500 = 375
- MTF C gets .75 x 334 = 250

Scarce Resources

- MTF A takes care of all patients
  - Wastes 42 units
- MTF B takes care of all patients
  - Wastes 42 units
- MTF C cannot take care of 84 patients
  - 84 patients become ill and need to be treated at civilian MTF, costing $84M in Managed Care
- TRICARE Managed Care is a MUST FUND

Scarce Resources

- TMA has $84M it must take back from the 3 MTFs
- Each MTF must take $28M out of budget

Scarce Resources

If your MTF incorrectly reports data, and so receives more resources than it needs or is entitled…

- Will cause a correctly reporting MTF to receive less than it needs or is entitled…
- Will cause care to be provided in a more expensive manner…
- Will cause to MHS “business” to fail

Objectives

- Understand terminology
- Understand what relative value units are
- Understand Military Health System RVUs, the basis of Prospective Payment System
- Understand how you earn relative value units
- Understand how to apply relative value units

Types of Workload Measurement

- **Professional Services** (not to include anesthesia) – Relative Value Units $83
- **Inpatient Institutional** – Relative Weighted Product (RWP) $6,877 (note: for Mental Health it is bed days $614)
- **Outpatient APV Institutional** – Ambulatory Payment Classification
- **Emergency Department Institutional** – APC
- **Observation Institutional** - APC
- **Anesthesia Professional** - procedure base units plus time units

Inpatient Institutional – Relative Weighted Product (RWP)

DRGV22	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
1	CRANIOTOMY AGE >17 W CC	3.3344	7.5	10.0
2	CRANIOTOMY AGE >17 W/O CC	1.9467	3.6	4.6
3	CRANIOTOMY AGE 0-17	1.9767	12.7	12.7
370	CESAREAN SECTION W CC	0.8981	4.2	5.4
371	CESAREAN SECTION W/O CC	0.6221	3.2	3.5
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5460	2.7	3.5
373	**VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES**	**0.3601**	**2.0**	**2.2**
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.6642	2.7	3.3
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.5810	4.4	4.4
504	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GFT	13.0063	23.1	29.3
505	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GFT	1.8727	2.3	4.4
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	4.0604	11.6	16.2

Relative Weighted Product

- Derived from the ICD diagnosis and procedures
- MHS has different DRGs (a few additional) than the civilian sector
- Reflection of inpatient
  - Nursing
  - Technician
  - Facility costs
- Professional services (i.e., doctors' rounds and procedures for inpatients) are not part of an RWP

Ambulatory Payment Classification

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate
96900	S		Ultraviolet light therapy (Actinotherapy)	0001	0.4007	22.83
38220	T		Bone marrow aspiration	0003	2.4779	141.20
60100	T		Biopsy of thyroid	0004	1.7081	97.33
42400	T		Biopsy of salivary gland	0005	3.7391	213.07
69000	T		Drain external ear	0006	1.6854	96.04
51080	T		Drainage of bladder	0007	12.4496	709.42
38300	T		Drainage, lymph node	0008	19.3572	1103.03
G0127	T		Trim nail(s)	0009	0.6817	38.85
G0247	T		Routine footcare pt w	0009	0.6817	38.85
19103	T		Bx breast percut	0658	6.6823	380.78
75982	S		Contrast xray exam bile	0297	5.2294	297.99
62230	T		Replace/revise brain	0224	38.8952	2216.37
64565	S		Implant neuroelectrodes	0040	49.2740	2807.78
36563	T		Insert tunneled cv cath	0119	125.9746	7178.41
69930	T		Implant cochlear device	0259	444.1223	25307.42

Insert Cochlear Device

- CPT code 69930, with professional services RVU of 16.79 work RVUs. Paid at a rate of $40/RVU, that is $671.60.
- On past slide, the APC is $25,000.

Ambulatory Payment Classification

- Reflection of INSTITUTIONAL outpatient
  - Ambulatory Procedure Visit non-provider component
    - OR nurses/techs
    - Central sterile
    - Supplies/equipment
    - Cost of the rooms
    - In MHS would include the cost of the anesthetic agent, but not C-arm used by radiology tech or radiology guidance
- About 850 different APCs, with about 5,500 codes matched to the 850 APCs.
- An APC is like an outpatient Diagnosis Related Group

Office/ER APCs

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate
99201	V		Office/outpatient visit, new	0600	0.9033	51.47
99202	V		Office/outpatient visit, new	0600	0.9033	51.47
99203	V		Office/outpatient visit, new	0601	0.9847	56.11
99204	V		Office/outpatient visit, new	0602	1.3977	79.65
99205	V		Office/outpatient visit, new	0602	1.3977	79.65
99211	V		Office/outpatient visit, est	0600	0.9033	51.47
99212	V		Office/outpatient visit, est	0600	0.9033	51.47
99213	V		Office/outpatient visit, est	0601	0.9847	56.11
99214	V		Office/outpatient visit, est	0602	1.3977	79.65
99215	V		Office/outpatient visit, est	0602	1.3977	79.65
99281	V		Emergency dept visit	0610	1.3544	77.18
99282	V		Emergency dept visit	0610	1.3544	77.18
99283	V		Emergency dept visit	0611	2.3926	136.34
99284	V		Emergency dept visit	0612	4.1139	234.42
99285	V		Emergency dept visit	0612	4.1139	234.42

CMS APCs 2005, this is the INSTITUTIONAL component of the visit

Anesthesia Base Units

- Base units include pre-surgical assessment, anesthesia administration
- Time is usually in 15 minute intervals

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CODE	2004 BASE UNIT	Anesthesia for:
00100	5	salivary glands
00102	6	plastic repair of cleft lip
00103	5	reconstructive procedures of eyelid
00104	4	electroconvulsive therapy
00120	5	external, middle, and inner ear; NOS
00124	4	external, middle, and inner ear; otoscopy
00126	4	external, middle, and inner ear; tympanotomy
00140	5	eye; NOS
00142	4	eye; lens surgery
00144	6	eye; corneal transplant
00145	6	eye; vitreoretinal surgery
00147	4	eye; iridectomy
00148	4	eye; ophthalmoscopy
00160	5	nose and accessory sinuses; NOS
00162	7	nose and accessory sinuses; radical surgery
00164	4	nose and accessory sinuses; biopsy, soft tissue

Understand Military Health System RVUs, the basis of Prospective Payment System

- Inpatient Professional (not anesthesia) – Work Relative Value Unit (RVU)
- Outpatient Professional (not anesthesia) – Work RVU
- Outpatient Doctor’s Office Institutional – Practice Expense RVU
- Laboratory – mostly Practice Expense RVU, some Work RVU
- Radiology – RVU
- Nurse and technician services – Practice Expense RVU
- Anesthesia – not paid separately, considered step-down

General Comments - Modifiers

- Modifiers – with the Standard Ambulatory Data Record (SADR) re-design, modifiers, quantities and the 2nd and 3rd evaluation and management codes will be available
  - How does this impact you?
  - Once the CAPER (redesigned SADR) is available, all servers will send SADRs back to 1 Oct 2002 to the central database

General Comments - Modifiers

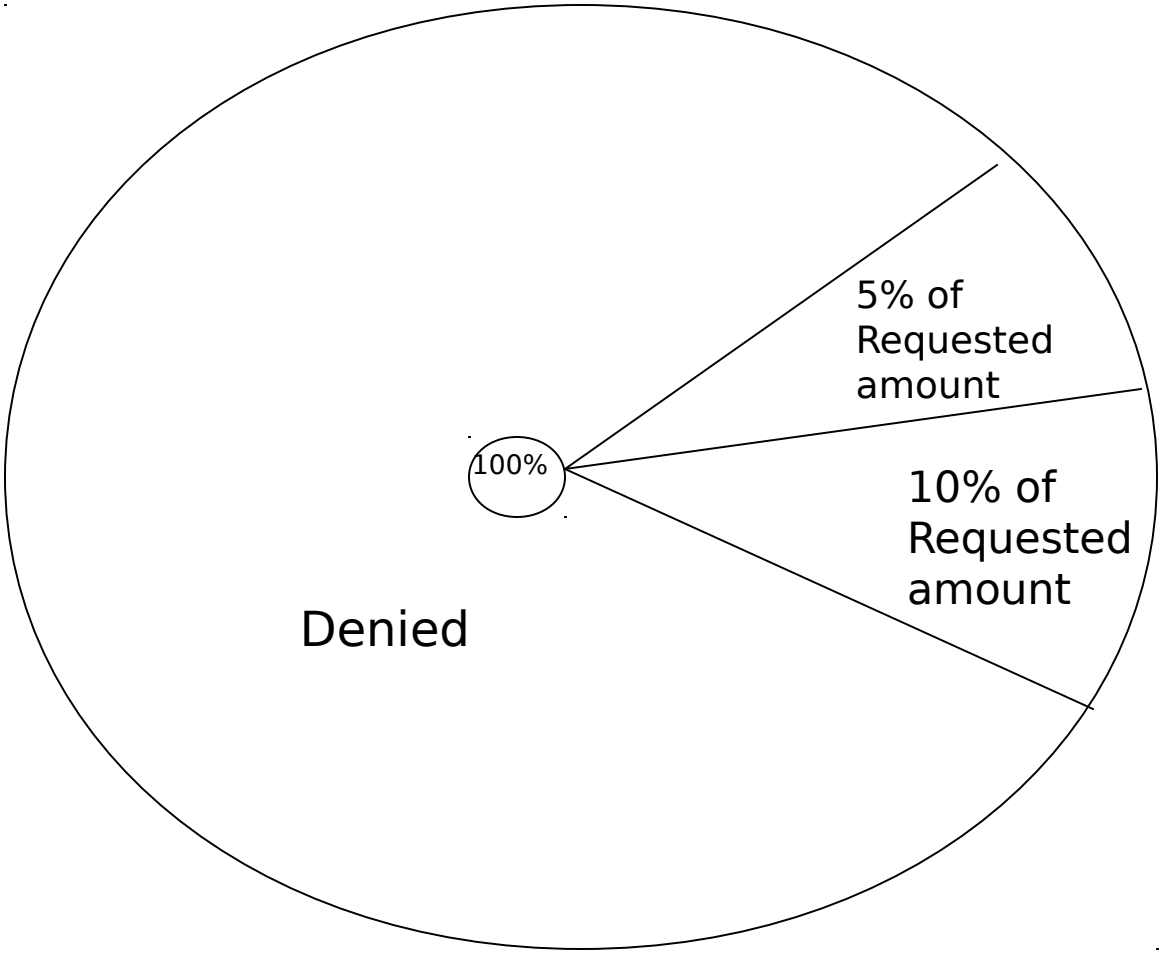
At this time, because modifiers are not available at M2 level:

- SADRs with both an E&M and procedure will not have the E&M counted unless the procedure is on the list at the end of the slides, unless the procedures are HCPCS or all procedure start with “9”
- This is because, usually if you have an E&M with an elective procedure, it is incorrectly coded

General Comments – New Codes

- CPT/HCPCS codes that are new as of 1 January will not have weights in the CHCS table
  - Weights were assigned in May
  - All “B” SADRS will have the May weights used when determining Prospective Payment System
  - Pretty much, MHS RVUs for new codes are retroactive

How Jeanne recommends Weights
You only get one dart with a blunt end, stand 30 feet away.



General Comments - CCE

- Coding Compliance Editor (CCE) does not use the MHS ICD table, the CPT table, and does not use the MHS RVUs
- CCE uses its own code tables
- CCE uses the Ingenix RVU tables, which are significantly different than the MHS RVU tables, particularly for procedures with a 10 or 90 day global period

General Comments - Billing

- Outpatient rates are established annually
- Outpatient rates are usually published at the beginning of June
- New codes are available 1 January (well, usually)
- Rates for new codes will be available when the annual rates are published
- No back billing – there was no rate when the service was done, so it can’t be billed

Relative Value Units are:

- A way to compare resources used to produce a product
- Examples of products are:
  - Office visits
  - Excision of a lesion
  - Delivering a baby

Inpatient Professional (RVU) – currently RWP is surrogate in the business plan

- See the “NA” – it means this would not be done in a doctor’s office
- See the “XXX” – it means not a global procedure

HCPCS	DESCRIPTION	WORK RVU	NON-FAC PE RVU	NA	FACILITY PE RVU	NA	MP RVU	NON-FAC TOTAL	FACILITY TOTAL	GLOB DAYS
99221	Initial hospital care	1.28	0.45	NA	0.45		0.07	1.80	1.80	XXX
99222	Initial hospital care	2.14	0.74	NA	0.74		0.10	2.98	2.98	XXX
99223	Initial hospital care	2.99	1.03	NA	1.03		0.13	4.15	4.15	XXX
99231	Subsequent hospital care	0.64	0.23	NA	0.23		0.03	0.90	0.90	XXX
99232	Subsequent hospital care	1.06	0.37	NA	0.37		0.04	1.47	1.47	XXX
99233	Subsequent hospital care	1.51	0.52	NA	0.52		0.06	2.09	2.09	XXX
99234	Observ/hosp same date	2.56	0.89	NA	0.89		0.13	3.58	3.58	XXX
99235	Observ/hosp same date	3.41	1.15	NA	1.15		0.16	4.72	4.72	XXX
99236	Observ/hosp same date	4.26	1.44	NA	1.44		0.19	5.89	5.89	XXX
99238	Hospital discharge day	1.28	0.54	NA	0.54		0.05	1.87	1.87	XXX
99239	Hospital discharge day	1.75	0.73	NA	0.73		0.07	2.55	2.55	XXX

CMS 2005 RVUs

CMAC Detail Screen for Procedure Code: 99217
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
99217	**OBSERVATION CARE DISCHARGE**

Effective Date: 01-Mar-06 **Correction Date:** N/A **Term Date:** N/A

CMAC for Category 1	$78.05
Category of Provider	Facility Physician
CMAC for Category 2	$78.05
Category of Provider	Non-Facility Physician
CMAC for Category 3	$66.34
Category of Provider	Facility Non-Physician
CMAC for Category 4	$66.34
Category of Provider	Non-Facility Non-Physician

Outpatient Professional (office visits) – currently the "work RVU" is part of business plan if in "B" MEPRS

		WORK	NON-FAC	NA	FACILITY	NA	MP	NON-FAC	FACILITY	GLOB
HCPCS	DESCRIPTION	RVU	PE RVU		PE RVU		RVU	TOTAL	TOTAL	DAYS
99201	Office/outpatient visit, new	**0.45**	0.49		0.15		0.03	0.97	0.63	XXX
99202	Office/outpatient visit, new	**0.88**	0.79		0.31		0.05	1.72	1.24	XXX
99203	Office/outpatient visit, new	**1.34**	1.13		0.48		0.09	2.56	1.91	XXX
99204	Office/outpatient visit, new	**2.00**	1.50		0.71		0.12	3.62	2.83	XXX
99205	Office/outpatient visit, new	**2.67**	1.77		0.95		0.14	4.58	3.76	XXX
99211	Office/outpatient visit, est	**0.17**	0.39		0.06		0.01	0.57	0.24	XXX
99212	Office/outpatient visit, est	**0.45**	0.54		0.16		0.03	1.02	0.64	XXX
99213	Office/outpatient visit, est	**0.67**	0.69		0.24		0.03	1.39	0.94	XXX
99214	Office/outpatient visit, est	**1.10**	1.03		0.41		0.05	2.18	1.56	XXX
99215	Office/outpatient visit, est	**1.77**	1.32		0.65		0.08	3.17	2.50	XXX

CMS 2005 RVUs

CMAC Detail Screen for Procedure Code: 99201
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
99201	**OFFICE/OUTPATIENT VISIT, NEW**

Effective	01-Mar-06	**Correction**	N/A	**Term**	N/A

CMAC for Category 1	$26.04
Category of Provider	Facility Physician
CMAC for Category 2	**$42.14**
Category of Provider	**Non-Facility Physician**
CMAC for Category 3	$22.13
Category of Provider	Facility Non-Physician
CMAC for Category 4	$35.82
Category of Provider	Non-Facility Non-Physician

Outpatient Professional (office visits)

- Notice CMS work RVUs same as MHS work RVUs for non-procedure services (2005 RVUs)

		WORK	MHS
HCPCS	DESCRIPTION	RVU	work RVU
99201	Office/outpatient visit, new	0.45	0.45
99202	Office/outpatient visit, new	0.88	0.88
99203	Office/outpatient visit, new	1.34	1.34
99204	Office/outpatient visit, new	2.00	2.00
99205	Office/outpatient visit, new	2.67	2.67
99211	Office/outpatient visit, est	0.17	0.17
99212	Office/outpatient visit, est	0.45	0.45
99213	Office/outpatient visit, est	0.67	0.67
99214	Office/outpatient visit, est	1.10	1.10
99215	Office/outpatient visit, est	1.77	1.77

Procedures

- Not global – for example, a refraction
- Global 0 days – uncomplicated services (e.g., topical anesthesia, and many moderate sedation procedures) just for that day
  - drain blood from under a nail
- Global 10 days – uncomplicated services for the day of the procedure and 10 days after the procedure
  - removal of foreign body from the nose
- Global 90 days – uncomplicated services for a day prior to the surgery, the surgery, and 90 days after the procedure
  - Treat a broken bone

HCPCS DESCRIPTION

30630 Repair nasal septum defect

Provider's work

Practice expense

Global days are usually n/a, 0, 10 or 90. This is 90 days of uncomplicated postoperative services

	FULLY	FULLY		FULLY	FULLY				
	IMPLEMENTED	IMPLEMENTED		IMPLEMENTED	IMPLEMENTED				
WORK	NON-FAC	FACILITY	MP	NON-FACILITY	FACILITY	GLOB	PRE	INTRA	POST
RVU	PE RVU	PE RVU	RVU	TOTAL	TOTAL	DAYS	OP	OP	OP
7.11	7.95	7.95	0.61	15.67	15.67	090	0.10	0.76	0.14

Modifiers

26	tc						56	54	55

Same as Non-facility because NOT done in office

Note: This is the CMS RVU table, not the MHS RVU table

CMS RVU Table

1. **Work – physician/privileged provider time**
2. **Non-facility Practice Expense – building, equipment, nurses, techs**
3. **Facility Practice Expense – nurses, techs**
4. **Malpractice – malpractice**
5. **Non-facility Total – Work + Non-Fac PE + Malpractice**
6. **Facility Total – Work + Fac PE + Malpractice**

- Work = used for PPS
- Non-Fac Tot = used for billing

Birth of an RVU

- RVUs are Professional and Practice Expenses associated with a Professional Services/CPT

- Provider-patient interaction (usually)
- Documented
- Coded with a
  - Current Procedural Terminology (CPT)
    - Evaluation and Management (E&M)
    - Surgical Procedure
    - Other Procedure
  - Healthcare Common Procedural Coding System (HCPCS)
    - Not all, many are durable equipment or supplies
- Look up the code in the RVU table

Example

- Patient seen in ER after getting in a fight with a Thanksgiving Turkey
- ER doctor documents ER visit to include 4 stitches in palm of left hand and tetanus shot
- Coded with 99282-25, 12002-LT, 90703, 90471

Example

Code	WORK RVU	Fac PE RVU	Institutional
99282 ER visit	0.55	0.15	flat rate
12002 stitches	1.86	0.93	1.09
90703 tetanus	0	0	0
90471 injection	0	0	t of institutional
	2.41	1.08	1.09+FR

Procedure Code 93526
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	Description
93526	RT & LT HEART CATHETERS

Effective Date:	01-Mar-06	Correction Date:	N/A	Term Date:	N/A

Pricing Type	Global	Professional	Technical
Physician	$2,786.74	$385.78	$2,400.96

Effective Date:	Correction Date:	Term Date:

Pricing Type	Global	Professional	Technical
NON-Physician	$2,728.87	$327.91	$2,400.96

Relative Value Units Are Only Part of What You Do

- Lots of what you do is not “codable”
  - Hall way consults
  - Effectiveness reports/civilian appraisals
  - Extra time spent consoling a bereaved patient
  - Shoveling snow/picking up debris after hurricanes/tornados
  - Discussing an AD mental health with his/her Commander
  - Participating on MEBs
  - Reviewing and returning consults for more info
  - Reviewing charts only to have the patient no show
  - Waivers/PHA/pre- and post deployment briefs
  - Quality assurance (over reading EKGs)
  - Preparing and giving talks at grand rounds
  - Medical inprocessing
  - Overseas clearances
  - ADAPT

Relative Value Units Are Only Part of What You Do

- Lots of what you do may be “codable” but that doesn’t mean there are RVUs
  - E-mail (0074T)
  - Signing forms for insurance/handicapped parking
  - Prenatal/diabetic/cardiac rehab/tobacco cessation teaching (S94xx)
  - Photorefractive keratectomy (PRK)
  - SARC (in May 2006, some H-codes received MHS work RVUs, which will be applied retroactively to 1 Jan 06)
  - Tattoo removal using laser (15999, an unlisted code)

Relative Value Units Are Only Part of What You Do

- Lots of what you do may be codable, but is not in your B MEPRS
  - Inpatient surgeries/rounds
  - Inpatient care “downtown”
  - Treadmills
  - Telemedicine (particularly store and forward)
  - Work you do manning assist (it is in someone else’s B MEPRS) – but you get the other guy’s work in yours

Relative Value Units Are Only Part of What You Do

- Some may have RVUs in one RVU system, but not in another
  - Telephone consults (MHS has work RVUs)
  - Obstetrical codes (CMS has all in 594xx, MHS has some; CMS doesn't for 0500F/0501F/0502F/0503F, MHS has RVUs)
  - Psychological testing (not in CMS, but in MHS)

Relative Value Units

- Multiple RVU systems
  - MHS
    - Work RVUs, EAS IV RVUs
    - Simple
    - PPS Work RVU, PPS Facility RVU
    - Individual Work RVU, Organizational Work RVU
  - CMS
    - Work RVUs
    - Practice Expense RVUs
    - Malpractice RVUs
  - Ingenix

RVUs depend on where you look

- **Worldwide Workload Report (WWR) and Medical Expense and Performance Reporting System (MEPRS)**
- No intensity-adjusted workload measures in either WWR or MEPRS
- **Only "count" visits**
- Common "non-counts" in B (outpatient clinic) MEPRS are:
  - Nurse/tech encounters
  - Some telemedicine
  - Reading EKGs
- RVUs in non-B MEPRS
  - A-MEPRS – inpatient surgeries, rounds
  - C-Dental
  - D-Lab and radiology professional components, anesthesia base units, EKGs
  - F-Immunizations; Hearing Conservation; Air Force civilian and VA hospital rounds, surgeries, procedures

RVUs depend on where you look

- **Standard Ambulatory Data Record (SADR)**
  - **Feed from the Ambulatory Data Record (created in the Ambulatory Data Module of CHCS and a feed from CHCSII goes to the ADM in CHCS to create the various feeds, such as the SADR and the Third Party Outpatient Collection System)**
  - **Does not include**
    - **Quantities (two breaks in the same bone, multiples of time sensitive codes such as psychologic testing…)**
    - **Modifiers (bilateral, postoperative care only…)**
    - **SADR redesign under development, will happen "soon" and will be called the CAPER**

RVUs depend on where you look

- ALL MHS **professional services** are collected in the ADM, and found on your server
  - A subset forms the SADR, which is what HQ uses
  - A subset forms the TPOCS feed, which is what billing uses

RVUs are NOT part of the RWP

- RVUs are NOT a reflection of inpatient nursing/technician/facility costs
  - Those are Relative Weighted Products (RWP)
  - Each Diagnosis Related Group (DRG) has an RWP
- Professional services (i.e., doctors' rounds and procedures for inpatients) are not part of an RWP

RVUs are NOT part of the RWP

- Billing. In the MHS, we take the DRG price, add 7% (based on MEPRS portion of A-MEPRS collected from privileged providers) and bill the professional component with the institutional DRG
  - Because, most MTFs aren't even close in coding professional inpatient services so we would not know what to bill
- BOTTOM LINE: Have folks record MEPRS properly!!!

Laboratory and Radiology

- Most of these services are collected in the laboratory or radiology module
- No feed from MTF to Clinical Data Repository (CDM) therefore not in MHS Mart (M2)
- Testing Ancillary SADR feed with lab and rad data now

- DO NOT COLLECT IN ADM TO GAME THE SYSTEM
  - All CLIA waived labs in clinic must have QW modifier

MHS Unique RVUs

- From the RVU table, for all global procedures having a 10 or 90 day post operative period, multiply the intraoperative portion by the “work” RVU – this is called “**Global Surgical Adjusted**”
- Provider Specialty Code 000-904, does not include Provider Specialty Codes for “clinics”
- Multiple physicians = both receive credit for PPS work and Organizational
- Count/non-count not a consideration

MHS Unique RVUs

- Use Ingenix table adjusted for MHS
- Health Care Summary Record RVU weight table in the MDR

- Uses all MEPRS

Examples

HCPCS	MOD	Work RVUS	EAS IV RVUS	30 CHARACTER DESC
99201	00	**0.45**	**0.95**	OFFICE/OUTPATIENT VISIT, NEW
99202	00	**0.88**	**1.67**	OFFICE/OUTPATIENT VISIT, NEW
99203	00	**1.34**	**2.47**	OFFICE/OUTPATIENT VISIT, NEW
99204	00	**2.00**	**3.51**	OFFICE/OUTPATIENT VISIT, NEW
99205	00	**2.67**	**4.47**	OFFICE/OUTPATIENT VISIT, NEW

MHS RVUs

HCPCS	MOD	DESCRIPTION	WORK RVU	FULLY IMPLEMENTED NON-FAC PE RVU	FULLY IMPLEMENTED FACILITY PE RVU	MP RVU	FULLY IMPLEMENTED NON-FACILITY TOTAL	FULLY IMPLEMENTED FACILITY TOTAL
99201		Office/outpatient visit, new	**0.45**	0.50	0.16	0.02	**0.97**	0.63
99202		Office/outpatient visit, new	**0.88**	0.79	0.32	0.06	**1.73**	1.26
99203		Office/outpatient visit, new	**1.34**	1.13	0.48	0.10	**2.57**	1.92
99204		Office/outpatient visit, new	**2.00**	1.51	0.71	0.12	**3.63**	2.83
99205		Office/outpatient visit, new	**2.67**	1.80	0.95	0.14	**4.61**	3.76

CMS RVUs

Which RVU to Use

- TMA Prospective Payment System
  - MHS RVUs
  - Compensated for lack of modifiers, quantities, multiple providers
  - **TMA and Service Representatives come to agreement every May on how to implement**
- Compare to Civilian Sector
  - CMS or Ingenix (found in CCE)

Relative Value Units - CMS

- http://www.cms.hhs.gov/physicianfeesched/pfsrvf/list.asp
- Download the **CY 2007** in .ZIP (**requires UNZip** software)
- Scroll down to “2007” with “RVU07A4 ” and click
- Scroll down to the download, and click
- It is 3.4MB (kind of large)
- These are not the MHS RVUs
- Send me an e-mail and I’ll send you the 4MB file of MHS RVUs

Global Days

- Provides time frames that apply to each surgical procedure.
- 000=Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.
- 010=Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.
- 090=Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount.
-
- MMM=Maternity codes; usual global period does not apply.
- XXX=The global concept does not apply to the code.
- YYY=The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.
- ZZZ=The code is related to another service and is <u>always</u> included in the global period of the other service.

Procedures – Discountable Surgical Procedures

Multiple procedure column of RVU table

0=No payment adjustment rules for multiple procedures apply.

1=If procedure is reported on the same day as another procedure that has an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 25%, 25%, 25%, and by report).

2=If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report).

3=Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family

9=Concept does not apply.

Anesthesia is Different

Carrier No.	Locality No.	Locality Name	2004 Anesthesia CF
00510	00	Alabama	16.82
00831	01	Alaska	29.22
00832	00	Arizona	17.55
00520	13	Arkansas	16.29
31146	26	Anaheim/Santa Ana, CA	18.36
31146	18	Los Angeles, CA	18.51
31140	03	Marin/Napa/Solano, CA	17.75
31140	07	Oakland/Berkeley, CA	18.08
31140	05	San Francisco, CA	18.96
31140	06	San Mateo, CA	18.61
31140	09	Santa Clara, CA	18.64
31146	17	Ventura, CA	17.78
31146	99	Rest of California*	17.27
31140	99	Rest of California*	17.27
00824	01	Colorado	17.18
00591	00	Connecticut	18.39
00902	01	Delaware	17.67
00903	01	DC + MD/VA Suburbs	18.45

How to Apply RVUs

- How much work did a doctor do?
- How much work did a family practice team do?
- If I have one AD Orthopedic Surgeon, where do I put her? Ft Wainwright or Sheppard
- Which care that is going to the network should I target

MEPRS

- Medical Expense Performance and Reporting System – you give us bad data, we make bad decisions
  - **AXXX – inpatient work, admit, rounds, discharge**
  - **BXXX – for your clinic work**
  - **EBCC – MTF committees (not staff meetings)**
  - **EKAA – MEBs – sitting on the boards**
  - **FALA – CME (pro staff usually)**
  - **GBAA – Readiness Training – Peace**
  - **GBBA – Readiness Training – War**
  - **GDAA – Deployed**
  - **GFAA – training for and doing the fitness test (sit-up, push-up, run, waist measurement) up to 3 hrs/week**

How to Apply

- Work RVUs/MEPRS Hours
- Work RVUS x Conversion Factor/ 18 days/month = $ earned / provider/month
- Compare RVUs to civilian sector (e.g., Optomized team = 25 Fac Tot RVU when you have 1 provider, 1 nurse, 2 med techs, 1 admin
  - –Based on average in reporting university teaching facilities

Yoder's Rule of Thumb

- If you can't find a code
  - Step back
  - Would a PRIVILEGED provider in the civilian sector do this?
    - Prenatal counseling – nope, done by nurse
  - Would an insurance company pay for this?
    - Hallway consult
    - Researching literature to figure out a diagnosis
    - Cosmetic surgery
  - Is this only done for active duty
    - PHAs, pre- and post deployment briefings
    - There is a "health assessment" code 99420
    - Profiles and waivers

Legal Medical Record

- Federal Rules of Evidence
- **Rule 803. Hearsay Exceptions; Availability of Declarant Immaterial**
- The following are not excluded by the hearsay rule, even though the declarant is available as a witness:
- (6) **Records of regularly conducted activity.** A memorandum, report, record, or data compilation, in any form, of acts, events, conditions, opinions, or diagnoses, made at or near the time by, or from information transmitted by, **a person with knowledge**, if kept in the course of a regularly conducted business activity, and if it was the regular practice of that business activity to make the memorandum, report, record or data compilation, all as shown by the testimony of the custodian or other qualified witness, or by certification that complies with Rule 902(11), Rule 902(12), or a statute permitting certification, unless the source of information or the method or circumstances of preparation indicate lack of trustworthiness. The term "business" as used in this paragraph includes business, institution, association, profession, occupation, and calling of every kind, whether or not conducted for profit.

  - *emphasis added to “a person with knowledge”

“…a person with knowledge…”

- If a patient comes in for a suture check, which is done by the technician without the presence or direct supervision of the provider, and documented by the technician,
  - But not signed by the technician
  - And the only signature on the document is the provider’s signature
- Is this a legal medical record?

Legal Medical Record

- No. It is not.
- Counter signatures
  - The individual doing the documentation signs that which he documented
  - Another privileged provider reviews the documentation and annotates the reason, such as “reviewed and concur with,” and then signs
- Initials are to be avoided unless there is a signature sheet in the record or the name and initials were used in another nearby entry so the documenter is always is obvious to a reader

Data Quality

- If a nurse is the only individual who interacts with the patient on the telephone, is it a legal medical record if the doctor signs it and takes credit for it?
- If a PT technician is the only one involved with patient care, is it a legal medical record if the PT signs and takes credit for it?
- Don’t compromise your integrity or commit fraud for Relative Value Units.

Need Data Quality

1. Legal Medical Record
2. Know Patient Population
   - Elevated blood pressure is not always hypertension
3. Prevention
   - Which children need vaccinations?
   - Which diabetics have had the foot check?

Need Data Quality

4. For manning
   - Where should the extra anesthesiologist go?
5. Determine which services should be closed
   - Should we close Cardiac Cath?
6. Non-covered benefits
   - Cosmetic surgery, if you don’t code as cosmetic (an bill), you are using appropriated funds for an unauthorized service

Need Data Quality

7. How much work is actually being done by a provider?
   - External resource sharing
   - Circuit riders
   - Services in other MTF
   - Inpatient professional services
8. Need “clean” financial audit

Need Data Quality

9. Patient Categories (PATCATs) – used for reimbursement
   - Change PATCAT when Active Duty retires
   - PATCAT needs to reflect when
     - Dependent is doing reserve duty
     - Dependent receives physical for Academy
   - Coast Guard – list sent to UBO at MTFs, but not fixed as responsible activity will not do

Need Quality Data

10. Use the correct reports for your analysis
    - Coding Compliance Editor has a type of civilian RVU table, NOT the MHS RVUs
      - Incorrect for most surgical procedures, particularly LASIX and PRK
      - Incorrect for obstetrics
    - Coding Compliance Editor does NOT have all the outpatient professional services (e.g., it does NOT have telephone calls)

Objectives

- Understand terminology
- Understand what relative value units are
- Understand Military Health System RVUs, the basis of Prospective Payment System
- Understand how you earn relative value units
- Understand how to apply relative value units

Questions

- National Provider Identification (NPI)
  - Provider
  - Institutional
- HIPAA Taxonomy
  - Provider
  - Institutional

MHS Unique RVUs - Simple

- Sum of “global surgical adjusted” Physician work RVUs without discounting. 100% of sum of all the weights.
- 1st E&M (notice, not 2nd, or 3rd as not in feed)
- 1, 2, 3, 4 Procedure (notice, not modifiers or quantities or 5th, 6th… as not in feed)

MHS Unique RVUs - Adjusted

- Not used anymore. There in case you used in the past – otherwise – don't even go here

- Not using "global surgical adjusted" – using the full CPT RVU for a procedure with a 10 or 90 day post operative period
- 100% of the highest weighted item, 50% of each additional procedure

MHS Unique RVUs – PPS/Individual/Organizational

- E&M not included if there is a procedure unless:
  - Procedures are on list of approximately 150 minor procedures for which CMS allows credit in conjunction with the E&M
  - Procedure codes with E&M are ALL HCPCS level II or begin with “9”

MHS Unique RVUs – PPS Work RVU

- Use “global surgical adjusted” Physician work RVU without discounting
- 100% of all weights, summed
- No longer sum the number of privileged providers on the SADR and multiply by the RVUs
- Used by MHS to allocate funding for ambulatory care

MHS Unique RVUs – PPS Facility RVU

- Use “global surgical adjusted” Non-facility practice expense RVU without discounting
- 100% of all weights, summed

- Used by MHS to allocate funding for facility burden of care

MHS Unique RVUs – Individual Work RVU

- Use “global surgical adjusted” Physician Work RVU with discounting
- 100% of highest weighted RVU and 50% of remaining RVUs, summed

- Tallies production for a single provider

MHS Unique RVUs – Organizational Work RVU

- Use “global surgical adjusted” Physician work RVU with discounting
- 100% of highest weight RVU and 50% of remaining RVUs, summed
- Multiply by number of physicians based on provider specialty code
  - Must use MDR as SADR only has the primary provider
- Tallies production workload for a clinic or higher

Coding Foundations

- Institutional - (the nurses, technicians, supplies, facility)
  - Hospital inpatient → ICD-9 diagnoses and procedures → Diagnosis Related Group (DRG) → Relative Weighted Product
  - Ambulatory Procedure Visit in a bedded MTF operating room → CPT procedure → Ambulatory Payment Classification (APC)
  - Ambulatory Procedure Visit in a non-bedded MTF operating room → CPT procedure → Ambulatory Surgery Center category (ASC)

Coding Foundations

- Institutional - (the nurses, technicians, supplies, facility)
  - Emergency Department → as of 12 Feb 2007 (28 Jan 2007 for National Capital Area) HCPCS of G0380/G0381/G0382/G0283 /G0384 → Ambulatory Payment Classification (APC)
  - Observation → CPT → APC
  - In the doctor's office → CPT "Non-facility Practice Expense"

CMAC Detail Screen for Procedure Code: 99281
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
99281	**EMERGENCY DEPT VISIT**

Effective Date:	01-Mar-06	**Correction Date:**	N/A	**Term Date:**	N/A

CMAC for Category 1	$18.07
Category of Provider	Facility Physician
CMAC for Category 2	$18.07
Category of Provider	Non-Facility Physician
CMAC for Category 3	$15.36
Category of Provider	Facility Non-Physician
CMAC for Category 4	$15.36
Category of Provider	Non-Facility Non-Physician

CMAC Detail Screen for Procedure Code: 99217
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
99217	**OBSERVATION CARE DISCHARGE**

Effective Date: 01-Mar-06 **Correction Date:** N/A **Term Date:** N/A

CMAC for Category 1	$78.05
Category of Provider	Facility Physician
CMAC for Category 2	$78.05
Category of Provider	Non-Facility Physician
CMAC for Category 3	$66.34
Category of Provider	Facility Non-Physician
CMAC for Category 4	$66.34
Category of Provider	Non-Facility Non-Physician

CMAC Detail Screen for Procedure Code: 99201
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
99201	**OFFICE/OUTPATIENT VISIT, NEW**

Effective	01-Mar-06	**Correction**	N/A	**Term**	N/A

CMAC for Category 1	$26.04
Category of Provider	Facility Physician
CMAC for Category 2	**$42.14**
Category of Provider	**Non-Facility Physician**
CMAC for Category 3	$22.13
Category of Provider	Facility Non-Physician
CMAC for Category 4	$35.82
Category of Provider	Non-Facility Non-Physician

Coding Foundations

- Professional (what the privileged provider did)
  - "Clinics" (e.g., Family Practice, Pediatrics, General Surgery, ENT) → CPT/HCPCS code → TMA Prospective Payment System (PPS) "**Work** Relative Value Unit (RVU)"
    - In civilian sector, if done in doctor's office/minor surgery suite, includes "Non-facility practice expense"
    - TMA PPS "Work RVUs" is a surrogate for all RVUs earned in the clinics
    - Issue for services with high "practice expense" such as Cardiac Cath Labs, Radiation Oncology
      - Using "CMAC" website for pricing – need to know when procedure is not done in doctor's office

Procedure Code 93526
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	Description
93526	RT & LT HEART CATHETERS

Effective Date:	01-Mar-06	Correction Date:	N/A	Term Date:	N/A

Pricing Type	Global	Professional	Technical
Physician	$2,786.74	$385.78	$2,400.96

Effective Date:	Correction Date:	Term Date:

Pricing Type	Global	Professional	Technical
NON-Physician	$2,728.87	$327.91	$2,400.96

Coding Foundations

- Professional (what the privileged provider did)
  - Understand when non-privileged providers do services normally billed in civilian sector
    - Anticoagulation Management - done by nurses, has practice expense, but not Work RVU – but need to consider each nurse encounter as if it was a provider encounter when considering sending these patients downtown
  - Telephone calls – not normally reimbursed in civilian sector, if a patient who receives a significant amount of care via the telephone is “sent downtown” the telephone calls frequently become office visits
    - Many are nurse triage, in the civilian sector these would be billed by the doctors, so include when considering who should be sent downtown

Coding Foundations

- Professional (what the privileged provider did)
  - Emergency Department – CPT code is only the professional component, not the institutional
  - Observation – CPT code is only the professional component, not the institutional
  - Anesthesia – 0xxxx CPT code → Base Units → plus minute of service base units
    - Anesthesia is the most common error when coding Ambulatory Procedure Visits

Coding Foundations

- Professional (what the privileged provider did)
  - Radiology – collected in “D” MEPRS
    - Seeing a lot of guidance coded in “B” Ambulatory Procedure Visits and Pain Management
      - Is it also being coded in “D” by radiology staff? – if so you are “double dipping” by getting RVUs in the “B” clinic and paid costs in “D” Radiology
      - If only coded in “B” is radiologist time also collected in the “B” ? If so, you are looking like your radiologists don’t do anything but you have really productive pain management providers

Tmt_DMIS_ID_Name	MEPRS3_	cpt	cpt_desc	Encounters	cpt_rvu
NMC SAN DIEGO	BBL	76005	FLUOROGUIDE FOR SPINE	520	312
WALTER REED AMC-W	BBL	76005	FLUOROGUIDE FOR SPINE	2005	1203
NH JACKSONVILLE	BBL	76005	FLUOROGUIDE FOR SPINE	312	187.2
NNMC BETHESDA	BBL	76005	FLUOROGUIDE FOR SPINE	495	297
WOMACK AMC-FT. BR	BBL	76005	FLUOROGUIDE FOR SPINE	68	40.8
BROOKE AMC-FT. SAN	BBL	76005	FLUOROGUIDE FOR SPINE	1511	906.6
DARNALL AMC-FT. HO	BBL	76005	FLUOROGUIDE FOR SPINE	190	114
59TH MED WING-LACK	BBL	76005	FLUOROGUIDE FOR SPINE	714	428.4
NMC PORTSMOUTH	BBL	76005	FLUOROGUIDE FOR SPINE	2250	1350
MADIGAN AMC-FT. LE	BBL	76005	FLUOROGUIDE FOR SPINE	668	400.8
NH BREMERTON	BBL	76005	FLUOROGUIDE FOR SPINE	30	18
LANDSTUHL REGIONA	BBL	76005	FLUOROGUIDE FOR SPINE	484	290.4
NH OKINAWA	BBL	76005	FLUOROGUIDE FOR SPINE	47	28.2

Coding Foundations

- Sometimes Professional, Sometimes Institutional
  - Physical Therapy and Occupational Therapy
    - Outpatient – Professional → CPT → RVU
    - Inpatient – institutional - problem, no PT or OT inpatient “A” MEPRS or step down “E” MEPRS
      - Do you collect inpatient PT in the inpatient MEPRS because they are doing inpatient institutional work?
      - Do you collect inpatient PT in the outpatient MEPRS and then the inpatient expenses are wrong?

Coding Foundations

- Physical and Occupational Therapy Example:
  - When closing an inpatient service, such as orthopedics (inpatient ortho will now be done across town at another MTF),
    - How much additional PT is needed across town?
    - How much additional PT will be available at the MTF loosing the service?

Coding Foundations

- Professional (what the privileged provider did)
  - Inpatient Hospital - a longstanding problem
    - “Count” and “non-count” – supposed to be all inpatient was “non-count”
    - Optometry – occasionally, but not frequently by any means, an inpatient had a prior outpatient scheduled appointment → “is this related to inpatient hospitalization”
    - “Fudging” to get more counts led to incorrectly collecting inpatient consults as “not related”

Coding Foundations

- Professional (what the privileged provider did)
  - **Inpatient Hospital - problem**
    - Incorrect “count” inpatient consults in the outpatient “B” MEPRS
    - Original Managed Care Support Contracts based on MTFs doing same amount of “count” visits
    - What to do?
      - Enforce that inpatient consults are not count and have those MTFs that had “fudged” have to pay the extra for not meeting their MCSC goals? Even though they were doing the same amount of word as before?
      - Instruct everyone to code inpatient consults in the “B” MEPRS?

Coding Foundations

- Professional (what the privileged provider did)
  - Inpatient Hospital - problem
    - Changed query in CHCS Ambulatory Data Module (ADM) from “is this related to the inpatient admission” to “are you in the same service as the attending”
    - Inpatient consults (i.e., CPT 9925x) not a problem as there is no “non-facility practice expense” as it is obvious that these cannot be done in a doctor’s office
    - Problem with procedures done by “other than the attending service”

Coding Foundations

- Inpatient Procedures by other than Attending Service Problem
  - Automatically feed to “B” Outpatient Clinic MEPRS
  - Credit in “B” for lumbar punctures and other consultant procedures
  - Credit in “B” for second specialty in major surgeries
  - Where is MEPRS time being collected? If time is collected in the “A” MEPRS, with RVUs in the “B” MEPRS
    - Inpatient Data is flowing to WAM/EAS IV
    - Receiving double payment in form of RWP and RVUs
  - Procedures that could be done in a doctor’s office have associated “institutional” so double institutionals
  - If billed, double billing institutionals, this is fraud

CMAC Detail Screen for Procedure Code: 62270
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
62270	**SPINAL FLUID TAP, DIAGNOSTIC**

Effective Date: 01-Mar-06 **Correction Date:** N/A **Term Date:** N/A

CMAC for Category 1	$74.22
Category of Provider	Facility Physician
CMAC for Category 2	**$189.80**
Category of Provider	Non-Facility Physician
CMAC for Category 3	$63.08
Category of Provider	Facility Non-Physician
CMAC for Category 4	$161.33
Category of Provider	Non-Facility Non-Physician

CMAC Detail Screen for Procedure Code: 99251
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS State Code: DC
State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
99251	INITIAL INPATIENT CONSULT

Effective Date:	01-Mar-06	**Correction Date:**	N/A	**Term Date:**	N/A

CMAC for Category 1	$39.33
Category of Provider	Facility Physician
CMAC for Category 2	**$39.33**
Category of Provider	Non-Facility Physician
CMAC for Category 3	$33.43
Category of Provider	Facility Non-Physician
CMAC for Category 4	$33.43
Category of Provider	Non-Facility Non-Physician

CMAC Detail Screen for Procedure Code: 99241
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
99241	**OFFICE CONSULTATION**

Effective Date:	01-Mar-06	**Correction Date:**	N/A	**Term Date:**	N/A

CMAC for Category 1	$37.60
Category of Provider	Facility Physician
CMAC for Category 2	**$57.49 (so facility cost is $20)**
Category of Provider	Non-Facility Physician
CMAC for Category 3	$31.95
Category of Provider	Facility Non-Physician
CMAC for Category 4	$48.86

Coding Foundations

- Not really institutional or professional
  - Ambulance → HCPCS A-code
  - Durable Medical Equipment → HCPCS
- Both institutional and professional
  - HCPCS C-codes, the pass-through codes

HCPCS	MOD	OWNER	Work RVUS	EAS IV RVUS	LAB NAMES	30 CHARACTER DESC					
11200	00	A	0.62	1.45		REMOVAL OF SKIN TAGS					
11463	00	A	2.80	7.64		REMOVAL, SWEAT GLAND LESION					
10040	00	A	0.94	1.75		ACNE SURGERY OF SKIN ABSCESS					
0500F	00	A	0.83	1.58		Initial prenatal care visit					
0501F	00	A	0.83	1.58		Prenatal flow sheet					
0502F	00	A	0.83	1.58		Subsequent prenatal care					
				FULLY		**FULLY**			**FULLY**	**FULLY**	
				Implement	**NON-FAC**	**Implement**	**FACILITY**		**Implement**	**Implement**	
			WORK	**NON-FAC**	**NA**	**FACILITY**	**NA**	**MP**	**NON-FAC**	**FACILITY**	**GLOB**
HCPCS	**Modifier**	**DESCRIPTION**	**RVU**	**PE RVU**	**Indicator**	**PE RVU**	**Indicator**	**RVU**	**TOTAL**	**TOTAL**	**DAYS**
11200		Removal of s	0.77	1.04		0.76		0.04	1.85	1.57	010
11463		Removal, swe	3.94	6.84		2.69		0.54	11.32	7.17	090
10040		Acne surgery	1.18	1.01		0.79		0.05	2.24	2.02	010
0500F		Initial prenata	0.00	0.00		0.00		0.00	0.00	0.00	XXX
0501F		Prenatal flow	0.00	0.00		0.00		0.00	0.00	0.00	XXX
0502F		Subsequent p	0.00	0.00		0.00		0.00	0.00	0.00	XXX

Data Quality

- Are you collecting coded workload in the same MEPRS that you are collecting the facility costs and the labor costs?
  - Radiology
  - Anesthesia
  - Physical Therapy
  - Inpatient professional services not in the attending's service

Data Quality

- Professional staff do many non-codable, non-medical type tasks. Don’t code, and don’t distort to try to make them codable:
  - Overseas clearances
  - Hearing conservation
  - Substance abuse
  - Family advocacy
  - Samples collected in the field for use in a training program…

Medical Necessity

- “Outpatient Admissions” don’t exist
  - Admit only if there is medical necessity
    - Not to “give nursing credit” when an Ambulatory Procedure Visit patient remains after the Ambulatory Procedure Unit closes for the evening
  - Patient remaining past midnight is not an automatic admission
  - Patient in observation more than 24 hours is not an automatic admission

Inappropriate Use of Funds

- Cosmetic Procedures
  - These are not covered benefits
  - If you don’t charge the patient,
    - It is a misappropriation of funds and
    - The money is not available for authorized care
  - Cosmetic procedures will have a primary diagnosis of V50.1

Institutional Considerations

- Institutional is separate from professional for:
  - Inpatient
  - Emergency Department
  - Observation
  - Ambulatory Procedure Visits
- Nursing and technician services are included in the institutional component and are not coded separately
- Dietician services are included in the inpatient institutional component

Know When to Include Practice Expense RVUs

- Work RVUs may not reflect worth of the service
- Practice Expense RVUs are important to consider for clinics with significant institutional components
  - Cardiac catheterization, radiation oncology

HCPCS	MOD	OWNER	Work RVUS	EAS IV RVUS	LAB NAMES	30 CHARACTER DESC				
93527	00	A	7.27	57.58		RT & LT HEART CATHETERS				
93528	00	A	8.99	60.02		RT & LT HEART CATHETERS				
93529	00	A	4.79	54.06		RT, LT HEART CATHETERIZATION				
93530	00	A	4.22	23.05		RT HEART CATH, CONGENITAL				
				FULLY		**FULLY**			**FULLY**	**FULLY**
				Implement	**NON-FAC**	**Implement**	**FACILITY**		**Implement**	**Implement**
			WORK	**NON-FAC**	**NA**	**FACILITY**	**NA**	**MP**	**NON-FAC**	**FACILITY**
HCPCS	**Modifier**	**DESCRIPTION**	**RVU**	**PE RVU**	**Indicator**	**PE RVU**	**Indicator**	**RVU**	**TOTAL**	**TOTAL**
93527		Rt & Lt heart c	7.27	50.46		50.46	NA	3.46	61.19	61.19
93527	TC	Rt & Lt heart c	0.00	47.14		47.14	NA	2.95	50.09	50.09
93527	26	Rt & Lt heart c	7.27	3.32		3.32		0.51	11.10	11.10
93528		Rt & Lt heart c	8.99	51.18		51.18	NA	3.57	63.74	63.74
93528	TC	Rt & Lt heart c	0.00	47.14		47.14	NA	2.95	50.09	50.09
93528	26	Rt & Lt heart c	8.99	4.04		4.04		0.62	13.65	13.65
93529		Rt, lt heart cath	4.79	49.42		49.42	NA	3.28	57.49	57.49
93529	TC	Rt, lt heart cath	0.00	47.14		47.14	NA	2.95	50.09	50.09
93529	26	Rt, lt heart cath	4.79	2.28		2.28		0.33	7.40	7.40
93530		Rt heart cath, (	4.22	18.89		18.89	NA	1.34	24.45	24.45
93530	TC	Rt heart cath, (	0.00	16.95		16.95	NA	1.05	18.00	18.00
93530	26	Rt heart cath, (	4.22	1.94		1.94		0.29	6.45	6.45

Using Data Correctly

- The Relative Value Units (RVUs) in the Coding Compliance Editor (CCE) are NOT the MHS RVUs.
  - CCE does not use MHS RVUs
    - OB, ophthalmology, surgical specialties, and many other clinics not correctly represented
  - Telephone calls do not flow to CCE so 10% of Army encounters and 8% of Navy and AF encounters are not in CCE

HCPCS	MOD	OWNER	Work RVUS	EAS IV RVUS		30 CHARACTER DESC
10080	00	A	0.94	3.44	credit w/E&M	DRAINAGE OF PILONIDAL CYST
10081	00	A	1.96	5.25	credit w/E&M	DRAINAGE OF PILONIDAL CYST
11010	00	A	3.35	8.74	credit w/E&M	DEBRIDE SKIN, FX
11011	00	A	4.94	12.97	credit w/E&M	DEBRIDE SKIN/MUSCLE, FX
11012	00	A	6.87	18.88	credit w/E&M	DEBRIDE SKIN/MUSCLE/BONE, FX
11740	00	A	0.37	1.22	credit w/E&M	DRAIN BLOOD FROM UNDER NAIL
11760	00	A	1.26	2.74	credit w/E&M	REPAIR OF NAIL BED
11981	00	A	1.48	3.22	credit w/E&M	INSERT DRUG IMPLANT DEVICE
12001	00	A	1.36	2.96	credit w/E&M	REPAIR SUPERFICIAL WOUND(S)
12002	00	A	1.49	3.14	credit w/E&M	REPAIR SUPERFICIAL WOUND(S)
12004	00	A	1.79	3.68	credit w/E&M	REPAIR SUPERFICIAL WOUND(S)
12011	00	A	1.41	3.14	credit w/E&M	REPAIR SUPERFICIAL WOUND(S)
12013	00	A	1.59	3.44	credit w/E&M	REPAIR SUPERFICIAL WOUND(S)
12014	00	A	1.97	4.06	credit w/E&M	REPAIR SUPERFICIAL WOUND(S)
12015	00	A	2.55	5.10	credit w/E&M	REPAIR SUPERFICIAL WOUND(S)
16000	00	A	0.89	1.75	credit w/E&M	INITIAL TREATMENT OF BURN(S)
16020	00	A	0.80	2.11	credit w/E&M	TREATMENT OF BURN(S)
16025	00	A	1.85	3.64	credit w/E&M	TREATMENT OF BURN(S)
20103	00	A	4.23	7.54	credit w/E&M	EXPLORE WOUND, EXTREMITY

21800	00	A	0.66	2.11	credit w/E&M	TREATMENT OF RIB FRACTURE
22310	00	A	1.80	5.17	credit w/E&M	TREAT SPINE FRACTURE
23600	00	A	2.02	5.98	credit w/E&M	TREAT HUMERUS FRACTURE
23605	00	A	3.35	7.90	credit w/E&M	TREAT HUMERUS FRACTURE
23615	00	A	6.44	12.44	credit w/E&M	TREAT HUMERUS FRACTURE
23620	00	A	1.66	5.24	credit w/E&M	TREAT HUMERUS FRACTURE
23625	00	A	2.70	7.07	credit w/E&M	TREAT HUMERUS FRACTURE
23630	00	A	5.06	9.61	credit w/E&M	TREAT HUMERUS FRACTURE
23650	00	A	2.33	5.57	credit w/E&M	TREAT SHOULDER DISLOCATION
23655	00	A	3.15	6.02	credit w/E&M	TREAT SHOULDER DISLOCATION
24500	00	A	2.21	5.94	credit w/E&M	TREAT HUMERUS FRACTURE
24530	00	A	2.41	6.13	credit w/E&M	TREAT HUMERUS FRACTURE
24640	00	A	0.96	2.50	credit w/E&M	TREAT ELBOW DISLOCATION
24685	00	A	6.07	11.25	credit w/E&M	TREAT ULNAR FRACTURE
25560	00	A	1.68	4.47	credit w/E&M	TREAT FRACTURE RADIUS & ULNA
25565	00	A	3.88	8.95	credit w/E&M	TREAT FRACTURE RADIUS & ULNA
25574	00	A	4.83	9.75	credit w/E&M	TREAT FRACTURE RADIUS & ULNA
25600	00	A	1.81	4.90	credit w/E&M	TREAT FRACTURE RADIUS/ULNA
25605	00	A	4.00	9.54	credit w/E&M	TREAT FRACTURE RADIUS/ULNA
25611	00	A	5.35	11.45	credit w/E&M	TREAT FRACTURE RADIUS/ULNA
25620	00	A	5.89	10.92	credit w/E&M	TREAT FRACTURE RADIUS/ULNA
26010	00	A	1.23	5.77	credit w/E&M	DRAINAGE OF FINGER ABSCESS
26600	00	A	1.35	4.17	credit w/E&M	TREAT METACARPAL FRACTURE
26605	00	A	1.97	5.59	credit w/E&M	TREAT METACARPAL FRACTURE
26720	00	A	1.15	3.83	credit w/E&M	TREAT FINGER FRACTURE, EACH

26725	00	A	2.30	6.50	credit w/E&M	TREAT FINGER FRACTURE, EACH
26770	00	A	2.08	5.12	credit w/E&M	TREAT FINGER DISLOCATION
26775	00	A	2.55	6.59	credit w/E&M	TREAT FINGER DISLOCATION
26952	00	A	4.35	12.79	credit w/E&M	AMPUTATION OF FINGER/THUMB
27193	00	A	3.83	8.73	credit w/E&M	TREAT PELVIC RING FRACTURE
27235	00	A	8.38	14.86	credit w/E&M	PERCUT SKEL FIX OF FEMRL FRACT
27236	00	A	10.75	18.29	credit w/E&M	OPN TX FEM FX,PROX END,NCK,FIX
27244	00	A	10.98	18.75	credit w/E&M	TREAT FEMRAL FRAC W/PLATE/SCRW
27245	00	A	13.99	23.45	credit w/E&M	TREAT FEMRAL FRAC W/INTRAEDULL
27265	00	A	3.48	6.76	credit w/E&M	TREAT HIP DISLOCATION
27266	00	A	5.16	9.49	credit w/E&M	TREAT HIP DISLOCATION
27506	00	A	12.02	20.78	credit w/E&M	TREATMENT OF THIGH FRACTURE
27520	00	A	1.97	5.58	credit w/E&M	TREAT KNEECAP FRACTURE
27530	00	A	2.60	6.66	credit w/E&M	TREAT KNEE FRACTURE
27750	00	A	2.20	5.91	credit w/E&M	TREATMENT OF TIBIA FRACTURE
27759	00	A	9.48	16.60	credit w/E&M	TREATMENT OF TIBIA FRACTURE
27780	00	A	1.83	5.22	credit w/E&M	TREATMENT OF FIBULA FRACTURE
27808	00	A	1.95	5.87	credit w/E&M	TREATMENT OF ANKLE FRACTURE
27822	00	A	7.58	14.91	credit w/E&M	TREATMENT OF ANKLE FRACTURE
27840	00	A	3.15	5.84	credit w/E&M	TREAT ANKLE DISLOCATION
28190	00	A	1.57	6.78	credit w/E&M	REMOVAL OF FOOT FOREIGN BODY
28450	00	A	1.31	4.12	credit w/E&M	TREAT MIDFOOT FRACTURE, EACH
28515	00	A	1.01	2.62	credit w/E&M	TREATMENT OF TOE FRACTURE
29105	00	A	0.87	2.05	credit w/E&M	APPLY LONG ARM SPLINT
29125	00	A	0.59	1.58	credit w/E&M	APPLY FOREARM SPLINT

29126	00	A	0.77	1.96	credit w/E&M	APPLY FOREARM SPLINT
29130	00	A	0.50	0.95	credit w/E&M	APPLICATION OF FINGER SPLINT
29131	00	A	0.55	1.28	credit w/E&M	APPLICATION OF FINGER SPLINT
29240	00	A	0.71	1.57	credit w/E&M	STRAPPING OF SHOULDER
29260	00	A	0.55	1.30	credit w/E&M	STRAPPING OF ELBOW OR WRIST
29280	00	A	0.51	1.32	credit w/E&M	STRAPPING OF HAND OR FINGER
29505	00	A	0.69	1.84	credit w/E&M	APPLICATION, LONG LEG SPLINT
29515	00	A	0.73	1.58	credit w/E&M	APPLICATION LOWER LEG SPLINT
29530	00	A	0.57	1.37	credit w/E&M	STRAPPING OF KNEE
29590	00	A	0.76	1.26	credit w/E&M	APPLICATION OF FOOT SPLINT
29799	00	A	0.00	0.00	credit w/E&M	CASTING/STRAPPING PROCEDURE
30300	00	A	0.83	4.70	credit w/E&M	REMOVE NASAL FOREIGN BODY
30901	00	A	1.21	2.57	credit w/E&M	CONTROL OF NOSEBLEED
30903	00	A	1.54	4.34	credit w/E&M	CONTROL OF NOSEBLEED
30905	00	A	1.97	5.54	credit w/E&M	CONTROL OF NOSEBLEED
30906	00	A	2.45	6.41	credit w/E&M	REPEAT CONTROL OF NOSEBLEED
31500	00	A	2.33	2.88	credit w/E&M	INSERT EMERGENCY AIRWAY
31515	00	A	1.80	5.51	credit w/E&M	LARYNGOSCOPY FOR ASPIRATION
31641	00	A	5.02	7.14	credit w/E&M	BRONCHOSCOPY, TREAT BLOCKAGE
31720	00	A	1.06	2.51	credit w/E&M	CLEARANCE OF AIRWAYS
32020	00	A	3.97	5.42	credit w/E&M	INSERTION OF CHEST TUBE
33010	00	R	2.24	3.20	credit w/E&M	DRAINAGE OF HEART SAC
33010	26	R	0.00	0.00	credit w/E&M	DRAINAGE OF HEART SAC
33010	32	R	0.00	0.00	credit w/E&M	DRAINAGE OF HEART SAC
33025	00	A	10.14	15.51	credit w/E&M	INCISION OF HEART SAC

33210	00	R	3.30	4.55	credit w/E&M	INSERTION OF HEART ELECTRODE
33210	26	R	0.00	0.00	credit w/E&M	INSERTION OF HEART ELECTRODE
33210	32	R	0.00	0.00	credit w/E&M	INSERTION OF HEART ELECTRODE
33967	00	A	4.84	6.69	credit w/E&M	INSERT IA PERCUT DEVICE
34201	00	A	8.41	12.99	credit w/E&M	REMOVAL OF ARTERY CLOT
36000	00	R	0.18	0.78	credit w/E&M	PLACE NEEDLE IN VEIN
36000	26	R	0.00	0.00	credit w/E&M	PLACE NEEDLE IN VEIN
36000	32	R	0.00	0.00	credit w/E&M	PLACE NEEDLE IN VEIN
36406	00	R	0.18	0.48	credit w/E&M	DRAWING BLOOD
36406	26	R	0.00	0.00	credit w/E&M	DRAWING BLOOD
36406	32	R	0.00	0.00	credit w/E&M	DRAWING BLOOD
36410	00	R	0.18	0.48	credit w/E&M	VP,AGE 3/>,REQ PHYSICIAN SKILL
36410	26	R	0.00	0.00	credit w/E&M	VP,AGE 3/>,REQ PHYSICIAN SKILL
36410	32	R	0.00	0.00	credit w/E&M	VP,AGE 3/>,REQ PHYSICIAN SKILL
36415	00	A	0.09	0.15	credit w/E&M	COLL VENOUS BLOOD VENIPUNCTURE
36416	00	A	0.09	0.15	credit w/E&M	CAPILLARY BLOOD DRAW
36425	00	R	0.76	0.98	credit w/E&M	ESTABLISH ACCESS TO VEIN
36425	26	R	0.00	0.00	credit w/E&M	ESTABLISH ACCESS TO VEIN
36425	32	R	0.00	0.00	credit w/E&M	ESTABLISH ACCESS TO VEIN
36488		Insertion of catheter, vein			credit w/E&M	deleted in 2004, not in CHCS list provided by HPA&E
36540	00	A	0.34	0.59	credit w/E&M	COLLECT BLOOD VENOUS DEVICE
36550	00	A	0.00	0.39	credit w/E&M	DECLOT VASCULAR DEVICE
36660	00	A	1.40	1.84	credit w/E&M	INSERTION CATHETER, ARTERY
38100	00	A	10.57	15.12	credit w/E&M	REMOVAL OF SPLEEN, TOTAL
38220	00	A	1.08	5.06	credit w/E&M	BONE MARROW ASPIRATION

43215	00	R	2.60	3.82	credit w/E&M	ESOPHAGUS ENDOSCOPY
43215	26	R	0.00	0.00	credit w/E&M	ESOPHAGUS ENDOSCOPY
43215	32	R	0.00	0.00	credit w/E&M	ESOPHAGUS ENDOSCOPY
43520	00	A	8.08	12.38	credit w/E&M	INCISION OF PYLORIC MUSCLE
43840	00	A	12.59	18.10	credit w/E&M	REPAIR OF STOMACH LESION
44050	00	A	11.35	16.21	credit w/E&M	REDUCE BOWEL OBSTRUCTION
44141	00	A	15.78	24.00	credit w/E&M	PARTIAL REMOVAL OF COLON
44143	00	A	18.60	27.35	credit w/E&M	PARTIAL REMOVAL OF COLON
44150	00	A	19.37	29.22	credit w/E&M	REMOVAL OF COLON
44950	00	A	8.09	11.62	credit w/E&M	APPENDECTOMY
44960	00	A	9.98	14.34	credit w/E&M	APPENDECTOMY
44970	00	A	7.04	10.47	credit w/E&M	LAPAROSCOPY, APPENDECTOMY
46040	00	A	4.01	8.30	credit w/E&M	INCISION OF RECTAL ABSCESS
46083	00	A	1.12	3.12	credit w/E&M	INCISE EXTERNAL HEMORRHOID
46610	00	A	1.32	5.40	credit w/E&M	ANOSCOPY/REMOVE LESION
50360	00	A	26.13	39.21	credit w/E&M	TRANSPLANTATION OF KIDNEY
51701	00	A	0.50	2.14	credit w/E&M	INSERT BLADDER CATHETER
51702	00	A	0.50	2.84	credit w/E&M	INSERT TEMP BLADDER CATH
51798	00	A	0.00	0.36	credit w/E&M	US URINE CAPACITY MEASURE
54150	00	A	1.45	2.22	credit w/E&M	CIRCUMCISION
56405	00	A	1.15	2.22	credit w/E&M	I & D OF VULVA/PERINEUM
56420	00	A	1.11	2.94	credit w/E&M	DRAINAGE OF GLAND ABSCESS
58999	00	A	0.00	0.00	credit w/E&M	GENITAL SURGERY PROCEDURE
59000	00	R	1.30	3.40	credit w/E&M	AMNIOCENTESIS, DIAGNOSTIC
59000	26	R	0.00	0.00	credit w/E&M	AMNIOCENTESIS, DIAGNOSTIC

59000	32	R	0.00	0.00	credit w/E&M	AMNIOCENTESIS, DIAGNOSTIC
59050	00	A	0.89	1.25	credit w/E&M	FETAL MONITOR W/REPORT
59051	00	A	0.74	1.04	credit w/E&M	FETAL MONITOR/INTERPRET ONLY
59151	00	A	6.88	10.54	credit w/E&M	TREAT ECTOPIC PREGNANCY
59899	00	A	0.00	0.00	credit w/E&M	MATERNITY CARE PROCEDURE
61107	00	A	4.99	8.31	credit w/E&M	DRILL SKULL FOR IMPLANTATION
61154	00	A	11.38	18.60	credit w/E&M	PIERCE SKULL & REMOVE CLOT
61312	00	A	18.64	30.10	credit w/E&M	OPEN SKULL FOR DRAINAGE
62230	00	A	8.00	12.94	credit w/E&M	REPLACE/REVISE BRAIN SHUNT
62270	00	R	1.13	4.21	credit w/E&M	SPINAL FLUID TAP, DIAGNOSTIC
62270	26	R	0.00	0.00	credit w/E&M	SPINAL FLUID TAP, DIAGNOSTIC
62270	32	R	0.00	0.00	credit w/E&M	SPINAL FLUID TAP, DIAGNOSTIC
65205	00	A	0.71	1.31	credit w/E&M	REMOVE FOREIGN BODY FROM EYE
65220	00	A	0.71	1.31	credit w/E&M	REMOVE FOREIGN BODY FROM EYE
66999	00	A	0.00	0.00	credit w/E&M	EYE SURGERY PROCEDURE
67005	00	A	3.98	7.05	credit w/E&M	PARTIAL REMOVAL OF EYE FLUID
67010	00	A	4.80	8.25	credit w/E&M	PARTIAL REMOVAL OF EYE FLUID
67141	00	A	3.63	8.70	credit w/E&M	TREATMENT OF RETINA
67145	00	A	3.75	7.78	credit w/E&M	TREATMENT OF RETINA
67220	00	A	9.18	16.07	credit w/E&M	DESTRCT;PHOTOCOAGLAT,1 OR>SESS
67500	00	A	0.79	1.61	credit w/E&M	INJECT/TREAT EYE SOCKET
69000	00	A	1.16	3.52	credit w/E&M	DRAIN EXTERNAL EAR LESION
69200	00	A	0.77	3.10	credit w/E&M	CLEAR OUTER EAR CANAL